Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTER
PO BOX 24809
HOUSTON TEXAS 77029

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-4666-01

MFDR Date Received
August 9, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Upon further review we are noting that the dates of service fall within ten weeks of the initial date of injury, therefore do not require a pre authorization for services rendered. Please reprocess and pay accordingly."

Amount in Dispute: $280.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier will stand on the denial of the charge(s) made the basis of this medical fee dispute. The following six physical therapy dates have been paid: 2-15-2011, 2-21-2011, 2-25-2011, 3-7-2011, 3-11-2011 and 3-14-2011. Services for the dates of 3-25-2011 were not preauthorized nor do they fall within the initial six visit timeframe."

Response Submitted by: Pappas & Suchma, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 25, 2011	97110, 97112 and 97140	$280.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the preauthorization, concurrent review and voluntary certification of healthcare guidelines.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated May 23, 2011
   - 19 – (197) Precertification/authorization/notification absent.
   - BL – To avoid duplicated bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of the EOR or clear notation.

Issues

1. Did the physical therapy services rendered on March 25, 2011 require preauthorization?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600 states in pertinent part "(p) Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following (i) the date of injury; or (ii) a surgical intervention previously preauthorized by the insurance carrier..."
   - The requestor disputes non-payment of CPT codes 97110, 97112 and 97140 rendered on March 25, 2011.
   - The requestor states in pertinent part, "...that the dates of service fall within ten weeks of the initial date of injury, therefore do not require a preauthorization for services rendered. Please reprocess and pay accordingly."
   - Review of the submitted documentation does not document that the treatment rendered was the first six visits of physical therapy following the evaluation when such treatment is rendered within the first two weeks immediately following the date of injury or a surgical intervention previously preauthorized by the insurance carrier.
   - Preauthorization was required for the disputed physical therapy services and was not obtained by the requestor. Therefore, MFDR cannot recommend reimbursement for CPT codes 97110, 97112 and 97140 rendered on March 25, 2011.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 23, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.